THE HOSPITALS YEAR BOOK 1960

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An Annual Record of the Hospitals of Great Britain and Northern Ireland, incorporating "Burdett's Hospitals and Charities," founded 1889

1960

Editor:
J. F. MILNE, M.C., B.Sc.(Econ.)

Advisory Editor:
S. R. SPELLER, O.B.E., LL.B.

The Institute of Hospital Administrators
75 PORTLAND PLACE, LONDON, W.1.

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EDITOR'S FOREWORD

THERE are again no major changes to report in this edition of the YEAR BOOK. The directory of regional hospital boards and hospital management committees, etc. (Section 4) has been revised to include particulars of the new Wessex region. Some additions have been made to the section of technical and general reference information (Section 18), and also to the guide to purchasing (Section 20). Every endeavour has once again been made to ensure that all information in the YEAR BOOK is accurate and as fully up to date as possible.

I would again express my very grateful appreciation to those officers of the Ministry of Health, the Department of Health for Scotland, the Regional Hospital Boards, Boards of Governors, Hospital Management Committees and Boards of Management, who have so readily afforded assistance and co-operation in making available information for this volume. My thanks are no less due to the officers of other Government departments, the Northern Ireland Hospitals Authority, the Isle of Man Health Services Board, and to those of the many other bodies and organisations who have equally readily supplied information.

THE HOSPITAL SERVICE

Progress and Problems

BY THE EDITOR

IN the field of the health services the outstanding event of the past year has undoubtedly been the introduction into Parliament of the Mental Health Bill and its subsequent speedy passage through both Houses to receive the Royal Assent at the end of July, 1959. Its enactment constitutes a new landmark in the history of the mental health services, and there can be very few instances in modern times where the findings of a Royal Commission have been so quickly followed by substantial and far-reaching legislation.

Broadly drafted to give effect to most of the recommendations of the Royal Commission, the Act has two principal objectives. The first is to make admission to hospital for treatment of mental disorder—whether mental illness or mental deficiency—as informal as possible and as far as possible the same as for securing treatment for a physical illness. It will in future be unnecessary for an order of any kind to be made for the reception of a patient into hospital for the treatment of any mental disorder, other than in criminal proceedings, provided the patient is willing to receive treatment. Also, the distinction between mental and mental deficiency hospitals and other hospitals is swept away, so that a patient suffering from mental disorder can be received in any hopital whatever, either without formality or under the procedure for compulsory admission, which procedure is to be based on medical instead of judicial certification. The second objective underlying the Act is to shift the emphasis of mental care and treatment from the hospital to the community, and to this end the powers of local health and welfare authorities are considerably strengthened and extended, particularly in relation to the provision of residential accommodation, social centres and training and occupational facilities.

One of the most general criticisms of the Bill in the course of its passage through Parliament was that—contrary to the recommendation of the Royal Commission—it for the most part only empowered local authorities to provide services, including hostels and occupational centres, and did not make their provision mandatory. The history of permissive legislation is strewn with good intentions, and it appeared to most thinking people that if we really believed in the need for community services on the lines recommended by the Royal Commission, their provision should be mandatory and not left to be determined by the particular outlook or the relative wealth or poverty of individual authorities. It was welcome, therefore, that during the passage of the Bill the Minister of Health announced that although the Bill itself would not be altered to make local authority powers mandatory, he proposed to secure the same result by issuing a direction under s.28 of the National Health Service Act soon after the Bill received the Royal Assent, which would impose on local health authorities the duty of providing the necessary mental health services, and that later he would issue a further direction requiring the submission within a given period of their proposals. Subsequently the Minister has, as promised, issued the first of these directions.

During its passage through Parliament a number of minor but useful amendments were made to the Bill.

These included alterations in clauses dealing with compulsory admission, a reduction in the period for which authority for detention or guardianship extends if not renewed, and provision for patients to apply to a mental health review tribunal for discharge at any period after a renewal of detention instead of only immediately after the renewal. Improvement was also made to those clauses dealing with the definition of the nearest relative and his rights in respect of a patient compulsorily detained. In general the amendments reflected the anxiety of Parliament for the liberty of the subject and were concerned to tighten still further the strict limits of the power of compulsory detention for treatment given in the Bill.

Inevitably, despite the general approval given to the Act, it still attracts a number of criticisms. The Royal Commission took the view that the idea that the liberty of the subject was safeguarded by the need for a judicial order before compulsory detention was largely an illusion, and under the Act such need is abolished. There are still many, however, who, whilst welcoming the right given to patients and to their nearest relative to have recourse to a mental health review tribunal if it is thought that compulsory detention for treatment is not justified, view with concern the fact that a person can be detained against his will simply on two medical recommendations, and would feel much happier if—except in cases of emergency—the compulsory admission procedure were still subject to the confirmation of a magistrate. Another matter which gives rise to anxiety is that under the Act hospitals are authorised to receive patients for treatment of mental disorder, but there is no longer any obligation on any particular hospital to admit them or on the Minister or the regional hospital board to see that they are admitted. This is in line, of course, with the general principle of sweeping away the distinction between mental and other types of hospital care and treatment, but it inevitably raises the question of what happens to the difficult type of patient whom nobody wants, a question which becomes the more cogent when the difficulties that have been encountered in securing admission to hospital for chronic sick patients are remembered. It would be a negation of the liberalising aims of the Act if by removal of any obligation on hospital authorities to receive a patient, it became the more difficult for any patient suffering from mental disorder to secure admission to hospital for necessary care and treatment. It is understood that to counter this the Minister of Health is going to make arrangements whereby regional boards will have a duty to find accommodation if any difficulty arises. There are again many people, however, who would have felt happier if some form of residual power to enforce admission had been written into the Act itself.

On another and much narrower plane, one of the most vocal criticisms of the Act has been that it does not provide for the continuance of the present system of administration in mental and mental deficiency hospitals whereby the medical superintendent is the chief officer of the hospital and responsible for its general management. But now that the responsible medical officer, that is to say the medical practitioner in charge of the treatment of the patient and not the superintendent, is to have the functions relating to discharge, renewal and leave of absence of patients, what little *raison d'être* may have previously existed for the medical superintendent disappears. Those who plead for his retention—by no means all psychiatrists and still less the medical profession as a whole—argue that a mental hospital is a therapeutic community in which all activities and arrangements have a direct bearing on the treatment of the patient and must therefore be under the guidance and control of a single doctor. Another argument is that a mental hospital needs a "father figure". Neither argument is very convincing. The concept of a therapeutic community is likely to be far better realised through the machinery of an effective medical staff committee, working in close concert with the non-medical staff, while if modern psychiatric treatment demands the creation of a father figure, the con-

sultant in charge of a limited group of patients would seem likely to discharge this role much more effectively than an administrator only rarely coming into direct contact with other than a small minority of the hospital's patients. But apart from this it is manifest that a hierarchical system of control is incompatible with the devolution—as is now rightly intended—of complete clinical responsibility for his patients to the individual consultant. The abolition of the hierarchical system in former local authority general hospitals has been most beneficial and there are no good reasons to suppose that the mental hospitals will not benefit by a similar change. Far from regretting that the Act makes no provision for the continuance of the hitherto existing office of medical superintendent, the existence of which rested on the discharge of legal responsibilities which are now swept away, any objective observer must welcome the opportunity now provided by the Act of assimilating the administration and medical organisation of mental hospitals to that of other hospitals.

The Act, and those changes in ideas and in organisation that are associated with it, can be expected in the long run to produce far reaching and much needed changes in our mental health services but drastic changes are not to be expected overnight. The Ministry of Health has already warned hospital authorities, for example, that they should not expect that in the near future they will be able to return to the community large numbers of patients in mental and mental deficiency hospitals who are not strictly in need of hospital care but who, pending the provision of hostels, have nowhere else to go. The initial effect of an expansion of community services, it is pointed out, is more likely to be a reduction in the number of patients coming into hospital than in the departure of patients already there who need hostel accommodation.

Whilst we must certainly look for substantial improvements in our mental hospitals—particularly for a reduction of overcrowding and for far better buildings and smaller hospitals—the key to the new situation is the role of the local health authority in providing community mental health services. It is therefore satisfactory that the Ministry has sent an early circular[1] to health authorities dealing with those recommendations of the Royal Commission Report which could be carried out under existing powers without waiting for the passing of the Act. At the same time a circular[2] was sent to hospital authorities about the action they will need to take in connection with the expansion of community services. These circulars stressed the importance of co-operation between the hospitals, the local authorities and general practitioners and suggested various means by which this could be achieved.

The circular to local authorities also gave some guidance on the type of services which authorities will have to develop, including junior and adult training centres, residential accommodation for the mentally disordered, home visiting services and social centres. Whilst no precise order of priority was put forward particular stress was laid on the need for training of children up to the age of 16 and on early provision for persons now living in the community for whom hospital admission would not be needed if suitable services were provided.

The duties laid on local authorities are heavy. Whilst they already have experience in the mental health services they are now being asked for a very great expansion of these activities, and they are going to be faced with a number of serious difficulties. The first is the problem of finance. Whilst in the long run increased expenditure on community services should be more than balanced nationally by a saving on hospital expenditure, local authorities will inevitably be more conscious of a heavy increase in their own expenditure. Many people regard it as most unfortunate that these services should have to fall within the new arrangements for block grants. The Minister of Health has tried to meet this criticism by pointing to the increased sum allowed for the mental health services in the general grant calculation for the next two years,

[1] Circular 9/59
[2] H.M. (59) 46

and in his circular he has said that as much priority as practicable will be given to applications for loan sanctions in respect of buildings for the services. Nevertheless it is to be feared that finance will present a problem for the next few years and it is to be hoped that the government will be prepared to reconsider the whole question if necessary.

Another problem of magnitude, and one also with financial implications, is that presented by the present serious shortage of suitably qualified social workers in the mental health field. With the publication of the Younghusband report one must hope that early action will be taken to try and meet this problem, but it must inevitably be some years before it is solved. Until it is, the intended shift of emphasis from hospital to community care for mental disorder can only partially be realised.

Hospital Building

The inadequacy of hospital capital expenditure has been a subject of repeated reference in these annual articles, but no apology is made for yet again commenting on the subject. In the first ten years of the national health service a little over £100m. has been spent on hospital capital development in England and Wales, and a further £21m. in Scotland. Virtually the whole of this expenditure has gone on first-aid repairs and on improvements and minor extensions to existing accommodation. Some 18 per cent. of the total has been spent on ward accommodation; 19 per cent. on special departments, including operating theatres; 7 per cent. on out-patient departments, 11 per cent. on staff accommodation; about 22 per cent. on engineering services, laundries and kitchens; and only 14 or 15 per cent. on new hospitals or major extensions. Except for the Vale of Leven Hospital, Dumbarton, no new general or mental hospital has in fact been built since 1948, or for that matter, since 1939.

Since 1957 the amount of money made available for capital expenditure and the proportion of it allocated for new hospitals and major extensions have been stepped up. By the end of 1958 work on new hospitals, though in some cases only site works, had begun at Hensingham, Huddersfield, Cambridge, Welwyn, Harlow, Swindon, Swansea, Newark (Balderton Hall) and Southport (Greaves Hall). In addition work was due to start on other new hospitals at Slough, Truro, Kingston-on-Thames, Wythenshawe and Birmingham. Altogether there were fifty-five schemes of capital development estimated to cost £100,000 or more on which some start had been made by the end of 1958 and there are a further 87 schemes of £100,000 or more on which some work was expected to begin in the current financial year, *i.e.* 1959-60, during which a total of a little over £25m. will, according to the estimates, be spent on all hospital capital works in Great Britain.[3] It is planned to increase this amount by a further £3-4m. in 1960-61.

On the face of it, such a programme may appear encouraging, but in reality it remains pitifully inadequate. In terms of the value of money the current total of £25m. still represents substantially less than was being spent on hospital building before the war, which was far from running at a high level then. As a proportion of total current hospital expenditure the £25m. amounts to less than 6 per cent. which may be compared with the proportion of about 20 per cent. prevailing pre-war in this country and a current proportion of nearly 25 per cent. in the U.S.A. Even if it were required to meet only normal replacement needs, this present rate of capital expenditure would be inadequate but as it is—with nearly one-quarter of our hospitals a century or more old, another half more than 50 years old and a vast legacy of capital arrears generally to be made good—it is quite ludicrously insufficient.

This, one is glad to note, is at last being more generally recognised, and as this article goes to press the announcements made by both the major political parties in the course of the General Election offer prospect of some stepping up of the present development programme. If this ensues it will become the more important that the service is in a

[3] Civil Estimates for the year ending 31st March, 1960.

position to ensure that the best use is made of the money made available to it, and to this end there is need for increased study and investigation of problems of hospital planning, design and equipment, and for better dissemination of the resultant information.

Work Study

It is a proper expectation that the replacement of obsolescent hospitals by new ones should bring with it economies in running costs. The current attention being directed to work study in the service should enhance the prospects of such economies being realised in practice, but apart from its potential value in relation to the planning and design of new buildings, the striking development of interest in work study which has taken place over the last year is to be generally welcomed. A service employing some 350,000 people, spending over £300 million a year and maintaining capital assets to the value of something like £2,000 million, cannot afford to ignore any modern tool of management. Whilst now generally accepting the need for work study, the service has still to make up its mind as to what extent it should be undertaken by outside consultants or by its own work study staff, and in the latter event how such staff are to be selected and trained. It will be surprising if, like other large-scale undertakings, it does not come to rely primarily on its own resources for work study. As yet, however, progress is limited. The O. & M. service of the Ministry of Health has now been enlarged and placed on a permanent basis, and regional boards and teaching hospitals have been given authority, which they have readily accepted, to appoint work study officers, but only on a niggardly scale. If work study is to be seriously undertaken within the service the staffing resources allocated for it must be very substantially enlarged.

Meanwhile two dangers have already made themselves apparent. One is that exaggerated hopes will be placed on work study as a panacea for all administrative problems, instead of its being regarded and used as one among a number of modern tools of administration, each useful and important, but not supplanting the need for sound executive judgment on the part of administrators. The other danger is that time and effort devoted to work study will not be matched by commensurate time and effort in applying its results. It is one thing to devise a new system or routine of working, and even to see that it is initiated; it is another to ensure that it is maintained. Aside from continuous oversight by administrators, much in this regard depends on the attitude and quality of supervisors at lower levels, and if the best results are to be obtained from work study the service will need to devote more attention than it yet has to the selection and training of supervisory staff.

Staffing

It has become an almost monotonous refrain of these annual articles to refer to the staffing difficulties of the hospital service, and there are regrettably very few directions in which the service is still not beset with difficulties. In one sector at least, however, the outlook has become brighter over the past year. Following Sir Noel Hall's report on the hospital administrative and clerical grading structure, Whitley Council negotiations have, with the help of arbitration, resulted in the establishment of a new structure of general administrative and clerical grades, with improved scales of salary. Subsequently, following a report by a fact-finding committee under the chairmanship of Sir Noel Hall, negotiations have taken place and agreement reached on new salary scales for designated posts. At the time of writing the terms of this agreement are not yet public, but the new scales will provide a much needed improvement over the old. While the general result of this salary and grading reconstruction will not be to put the hospital administrative service in the forefront of well-paid employments, it should ease the problem of recruiting and retaining administrative and clerical staff of reasonable quality. The last year has also seen some welcome improvement in the pay of nurses and some other categories of professional and technical staff. Long overdue, these improvements in remuneration betoken a belated recognition that the hospital service cannot indefinitely be run on a policy of cheap labour.

SECTION 2

DIRECTORY OF GOVERNMENT DEPARTMENTS AND STATUTORY BODIES